MAYO CLINIC

Referring a Patient to: Liver Transplantation Program

Please fax this form to: (480) 342-2677
For questions, please call: (480) 342-1010
Thank you for referring your patient to Mayo Clinic.

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Referring Physician Information

Referring Physician's Name			Date *(mm/dd/yyyy)*
Office Address			UPIN No.
City	State	Zip	Telephone
Reply to Fax No.	Contact Person		
Primary Care Provider			
Office Address		Contact Person	
City	State	Zip	Telephone

Patient Information

Patient Name *First* *Middle Initial* *Last*			Sex	SSN
Address			County	
City	State	Zip	Date of Birth *(mm/dd/yyyy)*	
Home Telephone	Work Telephone		Cell Phone	
Other Contacts				
Insurance No. 1	Policy No.	ID No.	Subscriber	Benefit Contact
Insurance No. 2	Policy No.	ID No.	Subscriber	Benefit Contact

Medical Information

Diagnosis

Please fax the following information: Most recent history and physical (within the last 90 days); list of current medications; Operative/Pathology reports; Current Pap Smear Exam note; Colonoscopy (within 5 years); Labs (CMP and CBC within 30 days); Radiology (CT, MRI, US Abdomen, X-rays and Mammogram within last year).

Medical Problems

Cardiac Disease ☐ Yes ☐ No	Ascites/Cirrhosis ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Colonoscopy ☐ Yes ☐ No	Hepatic Disease ☐ Yes ☐ No	Pulmonary Disease ☐ Yes ☐ No	Malignancy ☐ Yes ☐ No
GI Bleed ☐ Yes ☐ No	Smoking History ☐ Yes ☐ No	ETOH History ☐ Yes ☐ No	Substance History ☐ Yes ☐ No		**Height** _____	**Weight** _____